STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING: _____ B. WING _____	08/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HOSPITAL & HEALTH SERVICES	2001 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one (1) State complaint investigation. Dates of survey: 08/05/13 Facility number: 005075 Complaint number: IN00116402 Substantiated; No deficiencies cited. Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor St. Vincent Hospital & Health Services is in compliance with 410 IAC 15-1.5-7, Pharmaceutical services and 410 IAC 15-1.6-5, Psychiatric services, Hospital Licensure Rules. QA: claughlin 08/12/13	S 000		